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ABSTRACT

To discover the kinds of conflict encountered by hospital nursing staff members, nurses from several hospitals were asked to report the types of conflict they anticipated meeting during a work week. The answers were categorized into eight loci of conflict topics: (1) physician-nurse conflict, (2) uncooperative working norms, (3) superior-subordinate communication style, (4) fairness in staff assignments, (5) difficult patients, (6) performance surveillance by superiors, (7) communication with other departments, and (8) communication of new policies and procedures. The findings suggest that nursing staff conflict might be an organizational communication problem rather than an interpersonal dysfunction. Hospitals wishing to ameliorate some of the causes of staff conflict might consider establishing lateral and horizontal communication lines within the organization, forming task forces with specific assignments among the nursing staff, initiating simulations of resource demands, and restructuring around the information processing capabilities of the organization members. (Author/FL)

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CONFLICT ON THE NURSING STAFF: A Case for Overload Studies

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CONFLICT ON THE NURSING STAFF:

A Case For Overload Studies

ABSTRACT

This study examined samples of nursing staff conflict in three large hospitals. Data were gathered by a critical incidents method. Staff nurses reported the most common conflict situations they could expect to encounter in the next week. Eight loci of conflict topics were named by the nurses. This paper suggests that nursing staff conflict may be an organizational communication problem rather than an interpersonal dysfunction. The paper offers four reorganizational strategies which may ameliorate some of the causes of hospital staff conflict.

1. STATEMENT OF THE PROBLEM

A few years ago, the nurse was the head of the hospital. The nurse was the hospital's superintendent. But now, nursing is so fragmented that we have bits and pieces of authority all over the place. "No, I can't do that--that's not my job." "I can't help you now--besides, that's not my patient." The tech people aren't fragmented. They know the nurses are fragmented though, and they play on it. If the tech people don't want to draw blood, they just tell the nurse, "You draw the blood." The M.D. sits down at the station and looks over the charts and says, "Where's my culture on so-and-so?" Instead of him dialing the lab and finding out where his culture is, the nurse has to do it for him. He can't do it for himself. You know what we are? We're the hamburger in the middle of the bun. And every year our meat gets smaller and smaller. We're always caught in the middle. We're always the guys in the middle. (Head Nurse, Surgical Floor)

This quote is typical of many nurses' descriptions of the conflict they may have experienced in hospital staff relations. Interpersonal conflict, intra-, and inter-staff hostility mar many professional relationships in the nursing profession, disfigure professional satisfaction, and resist explanation from an interpersonal communication perspective. The use of an organizational communication perspective, may elucidate the perplexing phenomena in nursing conflict, and may

offer alternate strategies for conflict management. This paper will discuss the organizational communication components of nursing staff conflict, will describe a field study of staff nurses, and will offer suggestions for ameliorating nursing staff conflict.

The research literature richly documents the ranges, varieties, and consequences of staff conflict. Duldt (1982) points to the erosion of staff morale brought about when conflict is poorly managed within a nursing staff. Staff conflict causes loss of time (McConnell, 1981), deteriorates job satisfaction (Ivancevich, 1981; Kinzel, 1982; Edmunds, 1979) and is cited as one of the chief reasons for a shortage of nurses in the hospitals of the nation (Toufexis, 1981).

As numerous as are the citations which document nursing staff conflict, there are few studies which suggest that staff conflict may be an organizational, rather than an interpersonal problem. The majority of studies argue that staff conflict arises because the interpersonal needs of one partner are perceived as not being met by the other member of the conflict dyad. Huseman et al. (1977) and Pondy (1967) would argue that conflict may arise because each hostile person is really negotiating with the other over allocation of scarce resources in their social environment. Thus conflict would occur when one party disagrees about a perceived distribution of physical or emotional resources in the environment and negotiates a change in parity. Gordon (1981), Watzlawick (1967), and Walker (1979) would argue that conflict in the dyad arises from the linguistic ambiguities employed in the negotiation process itself. One partner may be unsure as to the factual and emotional loadings the other partner may be placing on words such

as "I don't want to be critical, but ..." or, "You seem to have a real problem in dealing with people." The dyadic models above, if applied to a nursing staff conflict problem, assume that nurses are able to solve conflict problems in the sequential order of their eruption, that nurses have the time to sit down with conflicting partners to solve a dilemma, and that nurses can devote uninterrupted attention to conflicts before them. However, if nursing conflict is viewed in its naturalistic setting a different picture of nursing conflict may emerge. In actual staff situations, a conflicting nurse may begin a negotiation process with a partner. The nurse will probably be interrupted during this process to attending to patient care duties. When these duties have been completed, the nurse may return to the site of the original conflict to finish the initial conversation. Here the nurse learns that the original partner also has been called away to complete patient duties. The first nurse now begins to discuss the original conflict with other nurses who are present at the conflict site and may obtain differing perceptions of the core problem from them. The new confidants, called away to complete other duties, now disclose the original conflict with others. The new audiences now create satellite discussions of the original conflict. In actual staff settings, nurses have very little time to devote to conflict resolution using the traditional style of the face-to-face confrontation.

If a theoretical frame is to be useful in analyzing staff conflict, then such a frame should acknowledge the constraints of the hospital organization which appear to inflame conflict, and those organization-

al constraints which make conflict resolutions difficult. The structure and function of the hospital organization may have powerful impact on how conflict is perceived and resolved on the nursing staff. Any discussion of nursing conflict which does not take into account the norms of discourse dictated by the hospital as organization, will blur theoretical vision and explanatory validity.

The hospital, as an organizational structure, is unique in a number of ways. These organizational characteristics appear to create unique communication patterns. The hospital staff regularly deals with life and death matters. In the hospital, interventionistic techniques are routinely applied to diseased tissues and flickering lives. Preservation of life and combat with death are stated and implied goals of the organization.

The hospital is also unique because staff members perceive that speed or efficiency of intervention is a defining characteristic of professional competence. Medical intervention often is rushed to the alleviation of human suffering. Thus, speed is justified on humanitarian grounds. In the heat of the rush, certain forms of rude and hostile discourse are justified. It is permissible to shout, demand attention, or to abuse coworkers because the rush of duties forces staff members to dispense with the niceties of polite discourse.

Hospitals are also structurally unique organizations. The organizational chart may describe the hierarchical structure, yet the formal structure has little to do with the actual power holders in the hospital. Physicians may have little to do with the formal hierarchy of the hospital, yet command vast amounts of influence as to allocations of

resources, or demands on staff members' time. Departments low on the organizational chart may command high power responses if they specialize in needed services from other departments. In fact it is often difficult to determine who has the real power in the organization. In such an organizational setting hospital staff members may utilize many informal channels of communication, may often disregard formal channels with apparent caprice, and often rely on subordinates to train new staff members who may have entered the staff carrying superior skill credentials. In such a setting the informal norms of work performance appear to be more powerful than the formal policies of the hospital. Thus each staff member must strike a careful balance between complying with formal and/or informal rules while being uncertain which staff members have the real power to enforce the rules.

As a structurally unique organization, the hospital imposes unique constraints on staff members and on the manner in which they perceive conflict. Such conflict could be analyzed using an organizational theory which accommodated norms of speed and norms of compliance with oblique power practiced in the hospital. Farace et al. (1977) offer such a method: The Structural-Functional approach. This model examines the communication patterns of an organization from five separate yet interlocking levels. By examining staff conflict on these five levels researchers can gain a systematic description of the complex roots of nursing staff relations. The model examines organizational communication by asking five questions.

a. What relations does the staff have with superior and subordinate structures within the organization? Many nurses are unsure of how

their staff fits within the larger administrative structure of the hospital, what persons are their immediate superiors, and what persons are their immediate subordinates. Because of this uncertainty, many nurses may feel great frustration at not being able to communicate with persons who hold real power within other departments, and frustration because they may be unable to identify the persons within those departments who might aid in affecting staff changes ("Getting Fed Up?" 1981). Since nurses often do not have a clear description of how their staff unit relates to other departments, they often find that other departmental members expect to issue orders to any nurse and expect her or him to comply with these work demands. The nurse often is expected to work cooperatively with a wide variety of persons within the hospital structure, regardless of the other person's level of competence, or the nurses' ranges of expertise (Citron, 1981).

b. What factors of the staff environment will affect change in the staff? Conflict may arise on the staff because nurses cannot accurately predict the factors in their environment which will affect changes of staff duties. Nurses' orders may be changed abruptly by a physician, even when the staff has formulated a clear procedure for patient care (Duldt, 1982). Other departments may make sudden changes in procedure and expect that the nurses on staff will quickly implement those changes (Showery, 1976). The nurse's professional environment may be defined as the systematic application of medical care to the patient, yet the nurse's environment can be changed quickly if someone "in authority" demands that the nurse refocus his or her professional attention away from the patient and on to another hospital

activity: filling out new forms, using new techniques to order equipment, fulfilling one physician's orders before attending to the orders of other physicians. Nurses have few guidelines for predicting who will have "authority" over a particular staff activity or nursing routine (Jameton, 1977).

c. What are the essential activities of the staff? Staff nurses may be in conflict with coworkers because they have differing perceptions as to the essential tasks of their duties. Nurses may assume that the essential duties of the staff center about the administration of systematic care. To this end, nurses create a Nursing Plan for each patient. This Plan involves assessment of the patient's needs, a design of health care regimen, an implementation of the regimen, and an evaluation of the regimen. The creation and execution of these Nursing Plans are the prime skills which differentiate the profession of nursing from the profession of medicine (diagnosis, prescription, intervention, and prognosis.) However, coworkers, physicians, and department heads may perceive the nurse differently. They may perceive nurses not as designers of nursing plans, but only as hospital functionaries who administer "quick" care to the patients at physicians' commands (Green, 1979). Others who work with the staff may consider that the essential task of the nurse is to execute physicians' orders faithfully, without error. Thus, to many coworkers, the essential duty of the nurse is to follow orders. To these people the nurse has no business in creating, or implementing care plans which may encroach upon the practice of physicians, pharmacists, and therapists (Cordes et al., 1981).

d. What ranges of behavior are associated with the staff and what ranges of behavior are perceived as being acceptable or unacceptable to the functioning of the staff? Many times, nurses have ranges of acceptable behavior concerning delivery of care set by hospital policy. However in practice, these policies may be altered by a variety of staff personnel with dubious qualifications or with little thought as to the consequences of these changes. For example, nurses should administer treatment only by permission granted in written orders left by the patient's physician. However, nurses may find that they have received only verbal orders from a physician and are often told by the physician to enact a "no code" procedure on a dying patient. (Rozovsky, 1981). Further, nurses are expected to consult with all staff physicians who attend the patient, before implementing care techniques. However, nurses may find that physicians may write orders without consulting with the nursing staff, and that those orders often may contraindicate accepted medical practice (Friedman, 1982). Further, a nurse may experience conflict when such orders violate the nurse's own ethical standards. Conflict may become even more critical if the rest of the staff decides to violate a physician's orders and pressures peer nurses to acquiesce (Stephenson, 1978).

e. Who or by what means are ranges of acceptable behavior maintained? Conflict may be experienced on the staff because there may be little agreement as to how the ranges of acceptable behaviors are maintained. There may be little agreement among staff members as to how work loads are to be distributed (Mayers, 1982). Nurses may be asked to perform techniques which are beyond their expertise (San-

droff, 1981). The nurse may have little voice in creating standards and criteria by which work loads are assigned, or by which abuses in practice are reviewed by peers. (Kramer, 1974).

Examining staff conflict from the Structural Functional perspective provides a clearer view of the interlocking organizational roots of this staff hostility. Given the present unique organizational structure of the hospital, conflict may be inevitable. Clearly, staff nurses in this type of organizational environment may be suffering from the condition of message overload exacerbated by their inability to predict the demands placed upon them from other departments and their inability to enforce professional autonomy within their own staff. Certainly, conflict in the nursing scene appears to arise from the fact that nurses must interpret a large number of messages in a short amount of time but do not have dependable criteria for establishing priorities for these messages. If staff members perceive that the demands of these messages exceed the staff's capacity to meet these demands, then a state of message overload is said to exist. Message overload has not only to do with the number of messages processed. Overload is a condition in which the staff perceives incoming messages: to be excessive in number, to be excessive in demands on members' time, to be obscure in terms of how and by what standards those messages are to be processed, and messages which defy the staff's ability to predict superiors' expectations for processing the data (Albrecht et al., 1982). Frustration and conflict could be expected to accompany the discourse of persons who could not predict the accuracy nor the level of agreement of staff messages (Roloff,

1981, p. 112). Though it appears "...that individuals can process more information in multi-dimensional situations than in uni-dimensional ones ... an individual's ability to process multi-dimensional attributes does not increase at the additive sum of his or her ability to process these same dimensions taken at one time. Instead, the rate of processing increases at less than the cumulative sum of the individual's ability to process uni-dimensional attributes" (Farace, et al., 1977, p. 104).

Overload may be defined specifically as the number of judgments that an individual must make in an environment, plus the speed and effort required to process messages by type, plus the level of quality desired in processing the messages, plus the predictability of message input by channel, plus the predictability of message input by content. Thus, in the hospital staff conflict scene, nurses could be viewed as suffering from overload if:

1. The number of orders given to them increases above a certain level and nurses perceive themselves as powerless to control the number.
2. If the speed required for processing those orders increases, and nurses perceive that they cannot increase their processing speed.
3. If nurses are required to maintain a certain quality level in processing the nursing orders, and perceive they are falling short of an acceptable level of quality.
4. If nurses are required to anticipate which physicians will administer orders, the types of orders, and the quality the phy-

sicians will demand in processing those orders, and perceive that they cannot accurately anticipate those demands.

5. And if nurses need to predict the content of orders, to be able to respond to data requests, and to be sources of information for a variety of persons of differing status levels who may wish to obtain patient data, and they perceive that realistically they cannot fulfill those roles.

Message overload as seen in the medical or nursing setting, is really a perceived incongruence in the norms of how incoming information is perceived by the staff or by the order givers, and how that information is processed by staff members. If all staff members are accurate in their perceptions and assessments of the action dictated by incoming information, and are in agreement as to how that information is to be processed, then the staff, from an organizational perspective, has little conflict. However, when expectations among staff members differ about the implied constraints of incoming data and differ as to the proper responses about those data, a state of conflict may exist among staff members. The analysis of data from a field study described below, sketches in some of the dimensions of message overload as gathered by a critical incidents report method among staff nurses in three large metropolitan hospitals.

2. DESCRIPTION OF THE FIELD STUDY

How is this type of staff conflict to be studied? One way is to ask the nurses themselves to report types of conflict they encounter in staff relations. Using a grounded approach, the researchers asked nurses from target hospitals to name the types of staff conflict they anticipated during the next working week. The answers were surveyed and categorized (N=144). Various loci of staff conflict were described and inferences were drawn from them. Loci or categories of conflict were fashioned using a content analysis format designed by the Litton-Hawes (1976) study of physicians' interactions. Categories were first named following an initial survey of the responses. The categories were narrowed and reapplied to the data mass. A series of judges reexamined the loci and their associated discourse samples. The composite reliability coefficient of interjudge agreement was .74 (Holsti, 1969). Seven loci emerged from the data mass. The data fell into the following categories as can be seen in table 1 below.

PHYSICIAN-NURSE CONFLICT:

Several interesting themes of message overload emerged when this locus of meaning was studied in detail.

a. Pressure Theme: Nurses perceived that physicians tested their nursing competence by demanding answers about a patient or procedure. The nurses complained about the speed of these demands (style of the physicians) and the fact that the physicians often demanded data to which the nurses did not have immediate access (content). "If you can recite patient information back to the MD in rapid order when he asks for it, then you're on top of things." "The MD one time may want to

TABLE 1

Loci of Conflict

N	%	LOCI LABEL
32	22.2	Physician-nurse discourse
26	18.	Uncooperative working norms
22	15.2	Attitudes of superiors or subordinates
17	11.8	Fairness of assignments
15	10.4	Conflicts with patients
14	9.7	Performance surveillance
11	7.6	Communication with other departments
7	4.8	Communication of new policies to staff

144 = total N

know about the family background of a patient--where do I get that? Another time he may want to know test values. At another time he may want to know the results on a psyc work-up. I have to switch gears instantly. The answer is not always on the tip of my tongue." Many of the nurses complained they were required to supply the answer to a physician immediately. If they could not supply demanded data, this hesitancy served as evidence of their lack of competence in the eyes of the physician. The nurses frequently seemed at a loss to provide rationale for the questions which the physicians asked yet many nurses perceived themselves as unable to challenge the physician's right to demand such questions.

b. Team Theme: Nurses of this study were frequently perplexed about the roles that they were required to play in comparison to the roles played by physicians on the health care team. "Sometimes it seems we're not on the same team. They (the physicians) could be better team players. While we're expected to tell the doctor about patient problems, often doctors do not do enough to warn us about patients of theirs who may be a problem." Many physicians not only were seen as withholding information from nurses but often inserted demands for information and task requests into the nurses' routine without regard to the appropriateness of the request. Nurses reported that physicians frequently interrupted nursing routine, and assumed that nursing duties were of less importance than medical duties. "Doctors feel that they are so important that they think they are the only individuals that need immediate attention." "The MD treats you only as a subordinate to him." "The MD thinks we're only here to clean bed pans."

This theme was complicated in emergency or crisis scenes (such as in the case of a "code blue") because general practitioners may not know correct crisis procedures and may be less skilled at ordering interventions than staff nurses. In such treatment scenes, nurses reported being reluctant to give orders to a physician even though they had the expertise to carry out the procedure that the physician did not. To meet this need, nurses reported several discourse conventions that they had developed to question physicians' orders. In a confidential tone of voice, they reported saying, "This is an unusually high dosage for this type of patient. Before I administer it I want to be certain I'm doing what you want. Are you sure you want this done?" "I wonder if there is an error here?" "Did the lab screw up again?" "Most of the doctors have found that the Ng tube goes down much easier if you put a gel cap over the end of the tube." Apparently much diplomacy was perceived as necessary in order to challenge a physician. The physician, by contrast, could abruptly challenge a nurse's procedures and practices.

c. Blame-Taking Theme: Another problem that emerged in discourse between physicians and nurses was of fault finding. If a laboratory test, a medication, or a piece of equipment was not administered, taken, or applied within the ranges of the physician's expectations, the nurses reported being blamed for failing to coordinate services in the hospital. "When there's a problem with the order, the physician will attack the nurse." Nurses of this sample were not responsible for staffing, or administering the support and ancillary services of the hospitals. Yet it appeared that physicians expected that nurses would

deliver the services according to each physician's unique specifications. "The doctor yells at the nurse as if something is her fault even though it isn't her fault at all." "Time and time again Doctor J gets Q brand eye drops when he really wanted Y brand eye drops. This infuriates him even though he didn't order them correctly in the first place." The task of coordinating these services was a major problem for the nurses. The nurses were often so preoccupied with administering nursing regimens, with answering physicians' questions about patients, and with meeting the nursing needs of the patients, that they had little time or the means to insure that other departments would coordinate material and services to the floor. "Many doctors order huge work ups from the lab and then simply forget to check up on the types of tests they have ordered and the results of the tests. They yell if their test results are not given to them on time. They continue to run the tests again and again. Those tests are expensive."

UNCOOPERATIVE WORKING NORMS:

If physicians of this study were perceived by the nurses as generating conflict, another item of irritation for staff nurses was the style which nurses themselves worked together. Apparently, nurses of this sample worked together in an uneasy communication climate of high sensitivity to negative criticism. "Nurses are extraordinarily sensitive to themselves and they don't want to hurt each others' feelings. You can praise them for fifteen minutes on what a fine job they are doing, but if you introduce one negative criticism, they will burst into tears." "This is a major concern--how do I give orders and crit-

icism without being bitchy? I'm not someone who wants to upset the whole unit." "How do I say what's really on my mind and not act like I want to take over the place?" Some reporting nurses wanted to change working norms on the staff but did not want to appear as a reformer of the norms of the unit. "How do I tell a coworker not to discuss the patient's personal problems in the hall?" Others resented receiving criticism which sought to return their behavior to the staff norm. "So I made a mistake on the meds. She chewed me out for that! Who does she think she is? Everybody makes mistakes!" This sensitivity to negative criticism was cited as a reason why some nurses resorted to a nonfunctional triad for resolution of intrastaff conflict. "Two people who don't get along, run to another staff member to complain about the first one. This kind of stuff makes you feel caught in the middle." Nurses felt that they could gain positive feedback and justification for conflict issues by seeking the aid of an intermediary and avoiding confrontation with the staff member who was the source of irritation. The working norm appeared to be one of avoidance of direct confrontation of conflicting partners in order to avoid negative criticism.

Another source of nurse-to-nurse conflict was when staff members fell below task expectations: "not getting the job done." Efficient completion of a task was cited as a highly prized working norm in the nursing staff. When others violated that task orientation, peer nurses began to resent this violation. "They spend more time talking on the phone with their boyfriends and avoid looking for work that needs to be done." "They show up for report late, and then hold up everyone

on the shift change by getting a cup of coffee for themselves." "Nurses who sit in the break room while their light is on really irritate me."

Peer nurses who worked beyond group norms were also resented by some members of this sample. "She's the one that the patients all ask for. She does a little bit extra for her patients. By spoiling the patients, she gets in trouble with the rest of the staff." The over-achieving nurse was viewed as uncooperative because patients began to expect similar treatment from all staff members. Apparently many nurses avoided hostile confrontations, were sensitive to ranges of productivity and avoided being identified as recalcitrant workers in order to preserve the prized norms of staff productivity levels.

ATTITUDES TOWARD STAFF COLLEAGUES:

Another source of conflict articulated by the nurses was found in the style in which superiors communicated with subordinates. For example, an experienced LPN may have needed to receive orders from, and be subordinate to a new BSN. If the BSN gave orders in a concise, efficient manner, the orders had a chance of being misperceived by the subordinate. "The new nurse they hired has a superior and snippy attitude." "The college nurses feel they are better than you and look down on you."

One way this attitude of superiority was projected was nonverbally. Nonverbal cues were interpreted heavily layered with attributed motive signals. "I could just tell by her look that she thought my way of treating the bed sores was not right." "All she has to do is just lift that eyebrow like she does and I know I did something wrong."

Subordinates appeared to resent aloof superiors, and would attribute condescension to the style a superior might use to issue an order. "She acts like it takes so much trouble to explain things and it's such a pain to show me how to do procedures." "I feel uncomfortable when asking about something I don't understand." "I don't ask the head nurse anything. She looks down on me because I can't ask intelligent questions." Subordinates hesitated to ask questions, even in teaching situations because: "truly competent nurses do not need to waste staff time by asking how to do a nursing technique."

FAIRNESS IN ASSIGNMENTS:

One conflict theme which was articulated repeatedly in this study was the fairness of staff assignments. Two items composed this conflict locus. First, the actual day of the assignment was a source of conflict: "Working on holidays." "Being called back to work on my day off." "Someone wanting to change a day off with you." "Some people see their reasons for getting their day changed as more valid than other people. My sister's getting married. I've got a bowling tournament."

The second conflict factor in assignments was a perception of inequity in distribution of difficult patients in each nurse's case load. Nurses felt frustrated and overworked if half their patients were difficult cases, or if they were given several patients with special care problems. Covert comparison and monitoring of patient loads took place among staff members. Nurses evaluated the difficulty of treating patients on their assigned load in comparison to the work loads generated by other nurses' case loads. The fairness issue appeared to

arise because the nurses perceived that superiors gave light patient loads to favorite nurses and gave heavy loads to nurses who did not conform to staff norms. "She makes such rotten assignments-- what's her problem anyway?" "She's got something against me. I guess I tell her what I think too often."

DISCOURSE WITH PATIENTS:

Given the reluctance of some of the nurses to work with difficult patients, it is not surprising to learn that patients themselves were a source of conflict. The chief form of conflict was "the patient who won't do what I tell him to do." Nurses objected to comparisons which some "troublesome" patients made about the quality of treatment. "The nurses are so much better at ---- hospital. They really care there." "Nurse --- changes my dressings much better than you do. I guess she knows what she's doing." "The day shift girls are friendlier than you girls on night shift." A few nurses reported that some patients made indiscreet inquiries about the nurses' private lives: "Do you girls get a lot of dates from the patients?" It was interesting to note that the "good patient" was also a copy of the "good nurse": one who was obedient to a wide number of authority figures. "Mr. --- is really a good patient. He listens to whatever anyone (of the nurses) tells him and does it without giving us a lot of objections."

PERFORMANCE SURVEILLANCE:

The feeling of being watched and monitored by superiors was another conflict generating factor for nurses of this survey. The frequency of evaluation, the criteria for evaluation, changing criteria for evaluation, and methods of reporting the evaluations to the subordi-

nates were all sources of conflict. Some superiors placed high value on the latest techniques and insisted that their nurses follow these techniques. Other evaluators placed a high value on traditional techniques and scorned nurses who used the new techniques. Standards for evaluation seemed to change with the nurse in power. "I just learned the routine around here and now she comes on the staff. Now I've got to change everything." "Why don't I ever hear any praise when I'm doing something right?" "He's always telling me how I'm not doing my job in front of the other nurses--or worse-- in front of a resident!"

COMMUNICATION WITH OTHER DEPARTMENTS:

Conflict arose from the fact that separate departments within the hospital had their own working norms and seemed reluctant to modify them in order to satisfy other departments. The pharmacy may have demanded that all drug orders be accompanied with a diagnosis of the patient. The laboratory may have initiated new credentials for receiving samples: only certain persons were allowed to take the sample on certain difficult cases. The nursing department may have required that the admitting office give full justification before assigning a patient to a unit. "We need a working IVAC up here immediately." "Why does central supply issue a ventilator without a nebulizer?" "I don't know why central supply won't just get on the elevator and BRING the vent up to our floor? They just parked it on the elevator and pushed the button for fifth floor." Clearly something more than a struggle for autonomy among departments emerges in this conflict scene. "When tests are not called back from the lab in a hurry, we get into trouble. Who do they think they are?" "When we called to

find out what happened to the test, the lab gets nasty with us." "The MD will hassle the nurse if the meds from the pharmacy are not on the floor on time. Yet the problem comes when the shift changes in the pharmacy. The nursing staff in the evening doesn't know about that, or the MD thinks that they will pass orders from one shift to the next." "Instead of just doing the test, the people in the lab spend more time arguing with us as to whose job it really is. Why don't they just go ahead and RUN the test?" Each department had little appreciation of how changes in one department would affect other departments and had little appreciation of the levels of interdependence which must be achieved for organizational cohesion.

COMMUNICATING POLICIES AND PROCEDURES:

The capacity to change the environment and to change the techniques of the nursing staff tended to generate conflict with nurses. Giving orders which differ from normal procedures, and expecting those orders to be followed from shift to shift was an example of this type of conflict. Adhering to the status quo appeared to be prized above the change. One reason cited for this resistance was the fact that new policies did not arise from the staff members themselves. New policies were also resented because floor nurses thought their expertise was being ignored and denigrated. "Don't they think we know how to get this done in a better way? They must think we're stupid down here!" As a result of the conflict, many procedures were changed radically from shift to shift. For example, in one hospital, the morning shift may have preferred to treat decubiti (bedsores) with an oil based ointment. The afternoon shift preferred dry heat for treating

the sores. The night shift preferred a drying ointment. Each shift thought their method was superior to other methods. However the head nurse decided that all cases of decubiti were to be treated with dry heat, and communicated this order by memo to the other units without consulting with the shift nurses. Her memo was ignored by the morning and night shifts. One nurse told these researchers that as many as ten percent of these procedural changes were ignored by the other unit nurses. The decision to ignore an order appeared to be an informal norm but one with which the entire unit would comply. Many staff members resented a head nurse and ignored the superior's memos as a means of sending informal feedback to the superior. "Since she never talks to me, why should I bother reading her written notes?"

3. DISCUSSION AND CONCLUSIONS

Norms affect not only the behavior of persons within an organization, but the means by which those persons process information, and the verbal patterns associated with compliance and/or violation of those norms (Knapp, 1978, p. 62). When these norms within an organization are ineffective in guiding the members' information processing competencies, a state of message overload may be said to exist. Message overload appears to be associated with the unique types of conflict observed in this study. The data of this field study elucidate the roots of nursing staff conflict, illustrate the consequences of allowing organizational norms to function without examination, describe how hospital norms restrict the choices of organizational members, and illustrate norms of behavior which have not kept realistic

pace with the changing information processing demands of an organization. When members of an organization utilize outmoded or inflexible norms to order their activities, then a situation of message overload is likely to lead to staff hostility and conflict. Members of the nursing staff serve as an excellent example of well-meaning professionals caught in a no-win situation of trying to conduct their duties in an organization stratified by strict norms which may be violated or broken with apparent caprice. From an examination of responses generated by staff nurses of this sample, conflict appears to arise when nurses are required to tolerate a professional environment where they cannot predict the level of information demands placed upon them. Nurses also appear to have little opportunity for creating a repertoire of appropriate responses suitable for speaking to superiors, for predicting the amount of information that will be given to them to solve dilemmas, and have little time to build interpersonal staff strategies which would alleviate interpersonal tensions affecting staff relations. When members of any organization are confronted with perceived overload, two choices are open to them: they may either ignore the indicators of overload or attempt to change the structure and norms of the organization so messages may be processed more effectively. To change the current norms of the hospital organization will require some major effort on the part of staff members.

Though analysis of data is incomplete and though physicians and other departmental members were not surveyed in this study, some conclusions seem warranted. The problems of nursing staff conflict appear to settle in two major areas: load and rules. The term load is

used here, in the sense that persons on the staff cannot predict the numbers, quality and difficulty of the messages that are being transmitted to them. The term rules is used here in the sense that nurses and other staff members do not appear to negotiate working rules among departments, superiors, and subordinates. So critical is the level of conflict within the hospital that the structure of the present organization may need reconfiguration if the hospital is to meet its stated goals. Richard McCormick of the Kennedy Institute of Ethics states: "The revolt of nurses ... will threaten the foundations of good hospital care, unless hospital policy is revised to give respect to nurses and reflect their contributions." (In the Aftermath of Roe v. Wade, a List of Ethical Issues, p. 3). It may be that the present structure of the hospital is such that these goals could not be met. Farace et al., (1977, p. 122 ff) make some solid suggestions for organizations which wish to restructure the configuration of their communication patterns.

a. Establish lateral and horizontal communication lines within the organization. This form of reorganization would allow key people in each department to have immediate access to ancillary departments, in order to have quick call for resources should the environment of one department change radically and find its resources rapidly depleted. Thus, when the nursing station had not received a proper piece of equipment, then at least one person on that shift would know whom to contact in central supply for rapid delivery of the equipment and where to locate the needed equipment. Further, the nursing staff should be given a priority status by virtue of their direct patient

contact, so that demands from the floor would receive a higher priority than any other departmental demands.

b. Form task forces with specific assignments among the nursing staff. Often changes in policy are handed down to nursing units with little concern for the people who will need to implement the changes. It appears that a wide number of policy problems could be solved if administrators would credential the nurses themselves to solve the patient care and patient documentation problems. Such tasks as charting patient Care Plans, and recording patient data are good examples of duties which could be solved by the floor nurses themselves. If the nurses themselves, assisted with electronic data keeping devices, could be given the task of reorganizing patient records, much of the nurses' time could be returned to direct patient interactions from the consuming tasks of clerical duties. Task force committees could solve the problems of standardizing modes of treatment, transmitting information from shift to shift, and for initiating professional dialogue with staff physicians.

c. Initiate simulations of resource demands. Simulations used in management systems, may be useful to predict key areas of the hospital where reorganization would be desirable. For example, the hospital treatment routine apparently rotates around the work schedule of many ancillary services. It may not be possible to give patients their morning medications until after ten o'clock in the morning, because the pharmacy may not begin its morning shift until 8:30. When medications are delivered late to the unit, the nurses often run into difficulty in serving meals to the patients. If the meals are not served

on time, then the dietary department complains about the delay. Certainly a study and simulation of alternate plans for the delivery of services to the patient, and for shift times in ancillary departments would make hospital reorganization more supportive to nursing needs. Nurses' direct patient care needs should be given high priority in the assembly of these simulations.

d. The organization could restructure around the information processing capabilities of the members of the organization. In this light, the most radical change may need to occur. Clearly nurses have the most frequent contact with patients, are the recipients of the most information about patients, and should receive the highest consideration when a hospital makes any attempt to restructure. All administrative functions of the hospital which effect direct patient contact should receive sanction from the nursing staff prior to implementation. Those who have the most contact with the patient should have the most responsibility and power in designing effective Care Plans. Such an organizational posture would return the hospital to its original structure when, in the words of the lead quote of this paper, "The nurse was the superintendent of the hospital." In the face of rising medical costs, of expensive care, and staff conflict which has diminished the number of nurses who remain in the primary care profession, perhaps such reorganization may not be as radical as the consequences of maintaining the status quo.

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